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EDITORIAL

Innovations for immediate impact: Small changes doctors and patients can make today without systemic reform

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SUMMARY

There are simple, free ways to improve health care even without systemic reform. Small, immediate changes in everyday practice could significantly impact outcomes. Four areas of focus for impact today are: 1) encouraging patients to maintain their own personal health record to reduce risks and duplication; 2) improving doctor-patient interactions through simple gestures that build trust; 3) supplying patients with a pre-appointment checklist designed to explicitly align agendas and expectations; and 4) adopting realistic, achievable goals that foster confidence rather than overwhelm. These "micro-innovations" require no new structures or funding but can enhance safety, efficiency, and improve patient experience by shifting both provider and patient behaviours within the clinical encounter itself.

Key Words: Personal health records; Physician-patient relations; Checklist; Health behaviour; Practice innovation

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INTRODUCTION

What doctors and patients can do differently—without changing the system

Every few years, debates about the future of health care resurface in professional circles, policy discussions, and the public domain. Much of the conversation gravitates towards comprehensive reform—major investment in technology, structural reorganisation of health systems, or sweeping legislative changes. While such initiatives are important, there are also meaningful opportunities to make improvements here and now. These opportunities for significant improvements lie in the everyday behaviours of doctors and patients, in things that could be done easily but are, at best, currently done inconsistently.

This editorial—coauthored by patients and doctors—considers four areas where small but impactful changes are possible: 1) patient responsibility for personal records; 2) the micro-skills of doctor–patient interaction; 3) the use of patient checklists before consultations; and 4) goal setting that is realistic and achievable. These areas demonstrate how health design can achieve real improvements without waiting for systems to change.

Patient responsibility for health records

Modern health systems are increasingly digital, yet gaps and errors in electronic health records remain enduring challenges. Records often exclude information generated elsewhere in the system: results of allergy testing, reports from other hospitals, or details of past adverse drug reactions. In emergencies or unscheduled admissions, these gaps in data put patients at risk and frustrate clinical decision-making.

Personal experiences illustrate this vividly. Patients unable to recall the exact proprietary name of an antibiotic allergy can be placed at risk of inappropriate prescribing. In other circumstances, missing results from past allergy testing can mean repeat testing at the patient's expense, or delays in prescribing lifesaving items such as adrenaline auto-injectors. Such examples underscore a truth long recognised in health informatics: centralised records cannot always be relied upon to provide seamless coverage.

Patient-held medical information is not new. Personal health records (PHRs) emerged in the 1990s as a means to bridge the information gap between patients and providers.[1,2] Unlike typical hospital-based records, PHRs are portable, patient-controlled repositories. When maintained diligently, they prevent duplication of tests, support continuity across care settings, and enhance patient autonomy. A simple, credit card-sized summary containing core elements—drug allergies, current medications, key diagnoses, and emergency contacts—offers a practical solution that could avert many unnecessary complications.

Encouraging patients to take responsibility for maintaining accessible records represents a cultural shift. It reframes the patient not as a passive recipient of care but as an active steward of their health information. Evidence shows that when patients are engaged in managing their own records, medication safety improves and errors decline.[3] Such a change is inexpensive, feasible, and can be implemented immediately at the level of individual doctor–patient relationships.

Doctor–patient interaction

Equally important is the quality of human interaction during the consultation.[4] Despite proliferation of technology and administrative pressures, the consultation remains the centre of clinical care.[5] How doctors greet, orient, and respond to patients sets the foundation for trust and cooperation.

Observations of patient encounters highlight considerable variability. In some cases, a doctor greets a patient with a wave, leads them into the consulting room without eye contact, immediately returns to the desk, and continues working on the computer. The interaction is functional but emotionally distant. In contrast, a more intentional practice involves standing to meet the patient, initiating a handshake (or equivalent culturally appropriate gesture), walking side by side into the consulting room, inviting the patient to enter first, and then positioning oneself to face the patient rather than the screen.

The difference in these approaches is subtle but profound. Communication research consistently demonstrates that non-verbal behaviours—posture, body orientation, and eye contact—influence patient perceptions of empathy and attentiveness.[6,7] In primary care, where relationships are often longitudinal, this foundation has measurable effects on adherence, satisfaction, and even health outcomes.[6] Importantly, improving from an impersonal to a more personalised interaction as described herein requires no additional time, training, cost, or systemic change. It depends only on recognising that small courtesies matter.

Patient pre-appointment checklist

Another tool that could be used in everyday practice is a pre-consultation checklist. A common source of dissatisfaction among patients is the perception that their key concerns were not addressed, even after an otherwise thorough medical review. This often arises from mismatched agendas—patients arrive with a particular worry in mind, while doctors follow structured clinical priorities that may not align.

This could be improved via a short checklist completed in the waiting room. With such a checklist, patients could be invited to state three things:

1. What I wish to learn,
2. What I wish to have answered, and
3. What I wish to achieve.

Additionally, a "word plot" encourages patients to circle up to three emotions that describe how they would like to feel by the end of the consultation—for example, "reassured," "understood," "heard," or "supported."

Before the clinician leaves the appointment, both the patient and provider could confirm that what was most important to the patient was covered in the appointment. It would offer immediate, repeated, daily feedback to the physician on whether the words they are using are actually achieving their intention. An effort to be "supportive" could be matched with immediate feedback at the end of the appointment to see if the patient actually perceived being supported.

Such techniques are simple, quick, and cost nothing to implement. Studies demonstrate that structured agenda-setting tools reduce unmet expectations, improve recall, and enhance both efficiency and patient experience.[8,9] They also equip doctors with practical insight into the consultation's relational goals, enabling them to address not just medical outcomes but emotional ones. If one patient is seeking to feel understood but another is seeking reassurance, then "I can see how difficult this is for you" is either a wonderful response from a clinician, or an inadequate one. And the surest way to know would be to allow the patient time before the appointment to clarify and state their needs.

Realistic goal setting in consultations

The final area concerns the setting of achievable goals. Lifestyle advice is a cornerstone of medicine, yet it too often falls into the trap of over-ambition. Patients are advised to overhaul their diet, quit smoking, reduce alcohol, increase sleep, and exercise—all in one consultation. The result is predictably discouraging. The patient may feel overwhelmed, attempt change, but fail, and then disengage entirely.

Behavioural science offers clear direction on this issue. Goals that are specific, measurable, attainable, relevant, and time-bound (SMART) are more effective than general exhortations. Moreover, change occurs incrementally, through small, cumulative adjustments rather than radical transformations.[9] Encouraging a patient who currently does no exercise to begin with a ten-minute walk three times a week is more realistic than advising the goal of 150 minutes per week. Over time, small victories compound into meaningful change.

Doctors may apply this principle in every consultation. Setting achievable, scalable goals not only improves adherence but also nurtures patient confidence. By contrast, setting multiple overextended goals within limited time fosters fatigue and non-compliance. The task is not to cover everything superficially but to focus sharply on what is possible now.

CONCLUSION: THE POWER OF SMALL CHANGES

The examples—personal responsibility for health records, deliberate attention to interaction, structured pre-appointment checklists, and realistic goals—share a common principle. They are not externally imposed, nor do they require new resources. They exist within the current architecture of practice and depend only on consistency.

In design terms, these are micro-innovations. Micro-innovations are small changes in process and behaviour that accumulate to transform user experience. They have an outsized effect precisely because they touch the relational and informational foundations of care. Doctors and patients may be waiting for systemic reform to solve the challenges of modern medicine, but doing so overlooks immediate opportunities already at hand.

What we choose to do differently—not someday, but at the very next consultation—may prove the most enduring design intervention of all.

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